Models of Integrated Care – Case Examples and Decision Points Arizona Department of Health Integrated Care Forum

January 26th, 2011
Phoenix, Arizona

Denise Levis Hewson, RN, BSN, MSPH,
Mike Lancaster, MD and
Richard Munger, PhD

Community Care of North Carolina

8 Integrated Care Models

Model 1: Improving Collaboration between separate providers

Model 2: Medical-Provided Behavioral Health Care

Model 3: Co-location

Model 4: Disease Management

Model 5: Reverse Co-location

Model 6: Unified Primary Care and Behavioral Health

Model 7: Primary Care Behavioral Health

Model 8: Collaborative System of Care

Community Care of North Carolina

Caveat

Community Care of North Carolina

- There are examples of pure implementations of the models
- Hybrid implementations are more common
- Models are adapted for local circumstances

Is There a "Best" Model

Community Care of North Carolina

- No gold standard model
- It depends what your goals are
- It depends what your local circumstances are

Model 1:
Improving Collaboration Between Separate Providers

Community Care of North Carolina

Kerry is a 51 yr. old female with hypothyroidism, fibromyalgia, a history of trauma, and treatment resistant depression.

Model 1 Implementation

- Physician/practice establishes a relationship a with a local therapist(s).

- If the patient agrees to the referral, the practice notifies the therapist via cell phone and the therapist calls the patient within 1 hour to introduce herself & engage the patient.

- A “release” & information exchange form is sent to the therapist at referral. A similar form is sent to the physician monthly—to report on progress in counseling.

Model 1 Adoption Issues

- Requires the least amount of systems change
- Requires local behavioral health professionals who are willing to collaborate with physicians
- Can significantly reduce referral failure rates which are typically 50-90%.
- Insurance reimbursement for the behavioral health professional can be a challenge, depending on the patient's insurance coverage

Model 1 Hallmarks

- Behavioral health & primary care are physically and operationally separate

- Differs from current practice because active collaboration is initiated

Model 2:
Medical-Provided Behavioral Health Care

Community Care of North Carolina

Mark is a 48 yr. old male who is being treated by his primary care physician for hypertension & COPD. Mark completed a routine behavioral health screening form that revealed he had recently developed panic attacks.

Model 2 Implementation

•In this rural practice, there is no practicing psychiatrist within 100 miles, so Mark's physician developed an ongoing email mentorship with a psychiatrist at the state medical college. He emails concise facts about Mark's case and gets feedback about medications within an hour or two.

•Mark's physician also has a manual of brief behavioral interventions. He uses the algorithm for "panic attacks" during 15- minute office visits, every other week for a few months.

Model 2 Adoption Issues

- Requires minimal systems change
- Psychiatric and other behavioral health professionals must be accessible
- Physicians must be willing to learn the behavioral health interventions which fit into an office visit
- Funds often must be found to support psychiatric consultation to primary care
- Regular screening for behavioral health problems is major secondary prevention approach

Model 2 Hallmarks

- Increases the ability of the physician (or mid-level) to directly deliver behavioral health care interventions within the existing practice

- Typically includes augmented capacity for psychiatric consultation

- Screening and referral can be the primary approach in this model

- If a patient is referred in this model, sometimes when patient is stable, she may return to the practice for behavioral health services, with the physician receiving consultative support from the psychiatrist/social worker who treated her.

Model 3: Co-Location

Toby is a 31 yr. old female who is experiencing fatigue and insomnia, concomitant to anxiety and depression, due to marital abuse, as well as past trauma (rape).

Model 3 Implementation

•Toby's primary care physician prescribes an SSRI and refers her to a therapist who practices in his office.

• Toby is reluctant but her physician assures her that the therapist is part of his healthcare team.

•Toby sees the therapist weekly for several months while the physician monitors her medication.

Model 3 Adoption Issues

•Physical space is required in primary care for a behavioral health professional(s). It would be possible to have space in an adjacent office suite.

•Insurance reimbursement for the behavioral health professional can be a challenge, depending on the patient's insurance coverage.

•Hourly counseling appointments may fill up quickly and make behavioral health less accessible.

Model 3 Hallmarks

- Primary care & behavioral health are in physical proximity, but operationally separate.

- There is enhanced engagement and communication because of proximity.

- Behavioral health services are typically traditional counseling approaches.

Model 4:
Disease Management

Community Care of North Carolina

Manny is a 41 yr. old male with chronic back pain due an injury on-the-job as a roofer. As a result, he is unemployed and now suffering from depression.

Model 4 Implementation

- Manny's physician's practice has a fulltime LPN depression case manager.
- The LPN meets with Manny and develops a depression action plan which follows a specific algorithm
- The LPN calls Manny weekly to check on how the medication is working and his compliance
- The LPN also coordinates Manny's physical therapy and communication with the Workman's Compensation agency
- The LPN meets monthly with Manny, after visits with the physician, to review elements of the depression action plan.

Model 4 Adoption Issues

- One of the best researched models
- May focus on one or more disease "registry"
- Varied health care professionals may deliver services: nurses, counselors, paraprofessionals
- Most or many of the disease manager's services are not billable, so a funding source must be identified

Model 4 Hallmarks

- Typically behavioral health screening is available
- Uses an allied health professional to coordinate care
- Case management and brief counseling may be provided

Model 5:
Reverse Co-Location - Bi-Directional Care

Community Care of North Carolina

Martina is a 54 yr. old female with schizophrenia. She receives disability and attends a psychosocial rehabilitation program. She has metabolic syndrome (including diabetes) due to long-term use of antipsychotics.

Model 5 Implementation

- An RN visits the psychosocial program weekly to monitor Martina's physical health
- The RN ensures that Martina gets routine checks of her liver functioning, which are necessitated by the psychotropic medication which she takes
- The RN communicates with psychiatrist who works with the psychosocial rehabilitation program
- The RN facilitates visits to Martina's primary care physician when she needs to be seen by a physician

Model 5 Adoption Issues

- Requires mental agencies which are willing to collaborate with primary care providers
- Space must be available in the mental health program
- While most of the health care professionals' time is reimbursable, billing logistics must be worked out

Model 5 Hallmarks

- Locates a healthcare professional (RN, mid-level or physician) in a mental health clinic or program

- Focus is on providing primary care to persons with severe behavioral health problems

- Persons with severe mental illness have more physical health problems and are at-risk for problems related to the medications which they take

Model 6:
Unified Primary Care and Behavioral Health

Community Care of North Carolina

Serena is a 28 yr. old female with bipolar disorder, Celiac disease, and she is pregnant. She receives her primary care at a Federally Qualified Health Center (FQHC).

Model 6 Implementation

- Serena's primary care physician leads a team of healthcare professionals.
- She sees a psychiatric nurse practitioner regularly to monitor her psychiatric medications
- She has difficulty with regular attendance in counseling, so her therapist tries to see her when she comes to see her primary care doctor or the nurse practitioner
- Serena has little insight to her psychiatric problem, but compliance is facilitated because she feels like she is "just" seeing her doctor

Model 6 Adoption Issues

- The funding of this fully integrated model can be a challenge, so it works best in a “closed” health system, such as the military, Veteran’s Administration, FQHC or HMO.

- An electronic medical record is virtually a requirement

- Recruitment of health care professionals who wish to work as a team to treat the whole person is essential

Model 6 Hallmarks

- Behavioral health & primary care are physically and operationally integrated
- Behavioral health screening & triage are typically available at the primary care visit
- A psychiatric prescriber is available to see patients if needed and (at least) traditional counseling is available
- Some models (Cherokee Health Systems, for example) offer intensive mental health services too, like ACTT or PSR. Other models refer for more intensive mental health services.

Model 7:
Primary Care Behavioral Health

Community Care of North Carolina

Adam is a 24 yr. old male who serves in the United States Air Force. He has gastritis, knee pain, insomnia and depression (because of difficulty adapting to military life).

Model 7 Implementation

Community Care of North Carolina

•Adam is seen at the base health clinic and screens positive for depression.

•In addition to treating the gastritis and knee pain, Adam's physician introduces Adam to a counselor, who evaluates Adam's depression

•The counselor develops an action plan for Adam's depression

•The counselor calls Adam weekly on his cell phone to check on his response to the medication and compliance with the action plan

•The counselor sees Adam at his primary care visits about 4 times, to monitor the action plan and provide brief counseling

Model 7 Adoption Issues

- Model aims to identify and serve the most patients with behavioral health (population perspective)
- Behavioral health staff must be competent at quick evaluations and brief interventions
- Insurance does not typically reimburse brief interventions or same-day services
- PMPM payment system may work best
- This is a stigma busting model because the patient often does not feel like he is getting a separate (mental health) service

Model 7 Hallmarks

- Behavioral health & primary care are physically and operationally integrated
- Behavioral health screening & triage are available at the primary care visit
- Psychiatric consultation on-site is available to the primary care physician, and the psychiatrist may evaluate patients directly if needed
- A licensed behavioral health professional delivers “bite-sized” interventions in the exam room
- This model emphasizes brief interventions with a large number of patients, and refers to specialized mental health services if more intensive services are needed

Model 8:
Collaborative System of Care

Community Care of North Carolina

Rodrick is a 19 yr. old male with Aspergers' syndrome, ADD and drug dependence. He lives at home with his mother.

Model 8 Implementation

Community Care of North Carolina

•Rodrick's physician's practice is part of a health network for person's with developmental disabilities.

•His physician has prescribed a stimulant medication for Rodrick's ADD for some time, and he recently screened positive for substance dependence

•A case manager works one-day a week in the practice and meets with Rodrick and his mother to arrange several services: substance abuse counseling for his marijuana use, social skills training at a local DD agency, and tutoring at a community college program.

•The case manager is the communication hub for all of these services and monitors Rodrick's progress

Model 8 Adoption Issues

- There must be a driving force and energy for the formation of systems alliances
- No overarching ongoing funding stream is necessary
- Can result in high levels of integration

Model 8 Hallmarks

- Uses one of the other models at the primary care practice
- The primary care practice forms close alliances with multiple service providers (around a specific theme)
- Creates a seamless system of services for the patient, even though multiple agencies are involved

Using Technology to Integrate Care

Community Care of North Carolina

- Training- webinars, lunch and learn, academic detailing, generic samples
- Regional phone consultations, email using professional organizations/academic centers
- Tele-psychiatry
- Web-based evaluations - ADHD evaluations for schools, parents; PHQ-9

Business Case for Integrated Care

Community Care of North Carolina

- ✓Medical Cost Offset
- ✓Leveraging
- ✓Effectiveness

Business Case for Integrated Care

- ✓Medical Cost Offset

  By addressing behavioral health issues, reduces ER visits, inpatient, and outpatient physical health care visits.

Business Case for Integrated Care

✓Leveraging

By addressing behavioral health issues, frees up physicians time to see more patients.

Business Case for Integrated Care

Community Care of North Carolina

✓Effectiveness

By addressing behavioral health issues, makes the physical health intervention more effective, e.g., co-morbid depression in diabetics, or compliance issues

Summary of Models: Hallmarks

Community Care of North Carolina

1. Collaboration	•Behavioral health & primary care are physically and operationally separate	•Differs from current practice because active collaboration is initiated
2. Physician-Delivered	•Increases the ability of the physician (or mid-level) to directly deliver behavioral health care interventions within the existing practice	•Typically includes augmented capacity for psychiatric consultation
3. Co-Location	•Primary care & behavioral health are in physical proximity, but operationally separate.	*There is enhanced engagement and communication because of proximity.
4. Disease Management	•Uses an allied health professional to coordinate care	•Uses an allied health professional to coordinate care
5. Reverse Co-Location	•Locates a healthcare professional (RN, mid-level or physician) in a mental health clinic or program	•Focus is on providing primary care to persons with severe behavioral health problems
6. Unified	•Behavioral health & primary care are physically and operationally integrated •Behavioral health screening & triage are typically available at the primary care visit	•A psychiatric prescriber is available to see patients if needed and (at least) traditional counseling is available
7. Primary Behavioral Health	•Behavioral health & primary care are physically and operationally integrated	•A licensed behavioral health professional delivers “bit-sized” interventions in the exam room
8. Collaborative System of Care	•Uses one of the other models at the primary care practice	•The primary care practice forms close alliances with multiple service providers (around a specific theme)

Summary of Models: Issues

Community Care of North Carolina

Model	Amount of Systems Change Required	Financial Challenges	Degree of Integration Achieved	Training Required
1. Collaboration	*	-	*	-
2. Physician-Delivered	*	-	*	**
3. Co-Location	**	*	**	-
4. Disease Management	**	**	**	**
5. Reverse Co-Location	**	**	**	-
6. Unified	***	***	***	**
7. Primary Behavioral Health	***	***	***	***
8. Collaborative System of Care	**	*	**	-

* These are relative designations, because models are typically implemented in a highly customized fashion.

Community Care of North Carolina

DISCUSSION / QUESTIONS